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SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

to the
DELEGATION OF THE CALIFORNIA STATE LEGISLATURE

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Good morning. It is a pleasure to be here together with those of you I have known and worked with for many years. Before I came to Congress in the mid-seventies, I served for 6 years on the California Assembly Health Committee. While we grappled with a variety of different health problems then, I know that the challenges California faces today in assuring the good health of its citizens are even greater.

The cost of delivering care is rising. At the same time, the number of Americans without coverage is increasing. And the recession has had a devastating impact on the States' ability to respond adequately to these demands.

Each one of my Congressional colleagues tells me the same stories from their states. Clinics shutting down for lack of funds. Some doctors and hospitals refusing to accept Medi-Cal patients or putting quotas on the numbers they will see. Working people losing their insurance when a family member gets sick.

These problems won't solve themselves. If we do nothing, things will just get worse. Costs will go up even more, and more people will find themselves without coverage for basic health care services.

California is one among a handfull of States that are seriously looking at reforming the health care system to increase access and contain costs. While I have been encouraged by the proposals for reform that are being generated -- by Mr. Garamendi and others -- I do not believe that, in the end, the States can succeed in health care reform on their own.

Now I will be the first to admit that if I were sitting in your seats, I would be very frustrated with the pace of the reform debate at the Federal level. In fact, I AM frustrated. One of the reasons for this inability to move the process along is a lack of leadership from the Administration, which is still trying to dodge any real reform. So far, the Congress itself has been unable to come to a consensus on which proposal to choose.

Part of the problem is that the debate continues to be clouded by what I call "fantasy solutions."

Fantasy #1: We can reform the health care system simply by regulating private insurance products for small businesses.

As you well know, the health insurance market for small businesses is in a death spiral. Instead of spreading risk, health insurers in this market are using medical underwriting, experience rating, benefits exclusions, and other devices to select only the healthiest groups and individuals. As a result, affordable insurance products are available to small businesses -- until an employee or dependent gets sick and needs coverage, at which point the premiums begin to climb rapidly, or the coverage is cancelled completely.

The Bush Administration would have you believe that we can have health care reform without controlling health care costs and without assuring coverage for the 36 million uninsured. All we need to do, they say, is to make sure that small businesses can, if they want to, buy a bare bones health insurance policy at an affordable price.

Fantasy.

Few would argue that regulation of the small business market is long overdue. We need to prohibit medical underwriting, guarantee issue and renewability of policies, narrow premium rating bands, and limit exclusions for preexisting conditions. But standing alone, these changes will just make matters worse, not better. Healthy groups that now have coverage will find their rates shooting up, and even more small employers will be priced out of the insurance market. Still others will continue not to purchase any coverage. And real health care reform will be further

delayed as opponents use the excuse of waiting to give the so-called small business insurance "reforms" a chance to work.

Fantasy #2: There is enough administrative waste in the system to pay for covering the uninsured and providing long-term care to all.

Many seem to think that there is so much fat in our health care system that if we could just make it more efficient, we could cover all of the uninsured for basic health care and still have dollars left over to cover long-term care. All we need to do is have one standard claims form for all physicians and hospitals, and eliminate the marketing, underwriting, and claims processing costs of private insurers, and we will free up billions for health care benefits for the currently uninsured.

Fantasy.

Is there waste in our health care system? Yes. Can we make the system more efficient? Yes. Will those savings pay for basic health benefits for the 36 million uninsured, or for long-term care for the 4 million frail elderly and disabled Americans who need it the most. No way.

Even if we were to make the most radical reduction in administrative overhead possible -- that is, adopt a Canadian-style system and replace the 1500 or so private health insurers with a governmental payor -- there would still not be enough savings to pay for basic health benefits for the 36 million uninsured, much less long-term care for our parents. And I don't have to tell you that, since one person's overhead is

often another person's job, the likelihood of such a change is slim.

Fantasy #3: We can reform the health care system by eliminating defensive medicine through so-called "malpractice reform."

This is a close cousin of the administrative waste fantasy. If physicians weren't constantly worried about being sued, the argument goes, they wouldn't order so many unnecessary tests or conduct so many unnecessary procedures. Eliminating this defensive medicine would reduce health care costs by 20 percent, according to the AMA. All we need to do is cap malpractice awards for non-economic damages, limit contingency fees, reduce the statute of limitations, allow periodic payments for awards over $100,000, and create incentives for binding arbitration, we can reduce defensive medicine and save billions.

Fantasy.

First, let's be clear on the size of the malpractice problem. According to the Congressional Budget Office, malpractice premiums account for less than 1 percent of health care costs -- about $6 billion annually. This is not insignificant, but reducing these costs won't pay for access to basic health care for the 36 million uninsured.

Secondly, there is no evidence -- no evidence -- that limiting awards to patients injured by malpractice will reduce defensive medicine. As you all know, California has had most of the recommended tort reforms on the books since the mid-70s. Despite some moderation in premium increases, I have not seen any data suggesting that health care costs and

the volume of services in California are significantly different from experience in other States.

Medical care is filled with uncertainty, and uncertainty results in unnecessary services. In addition, most physicians have financial incentives to order more tests and perform more procedures -- particularly when they have a financial interest in the laboratory or in the diagnostic equipment that their patients use. Changing these arrangements would have a much greater impact on physician clinical decisions than changes in the tort system.

Finally, if we are really serious about malpractice reform, then we have an obligation to help those patients who are the victims of clearly substandard medical care but never receive compensation for their injuries and to weed out physicians whose performance is poor. The Harvard Medical Practice Study found that 16 times as many patients suffered an injury from negligence as received compensation from the tort system. If we actually tried to establish a system that made all the victims of physician negligence whole, the costs would go up, not down.

Fantasy #4. We can control health care costs by unleashing market forces through managed competition.

The Bush Administration, among others, argues that we can control health care costs simply by encouraging people to enroll in managed care plans. People who might not want to enroll in a managed care plan and who are poor should be forced to do so if they want any health care coverage at all. These plans will then compete, not on the basis of who

can enroll the healthiest population, but on the basis of efficiency and value. They will organize and discipline high-cost providers, reducing the rate of increase in health care spending for private employers and the government alike.

Fantasy.

We've had market-based solutions before. Does anyone remember the Voluntary Effort? This is what the hospital industry promised the Congress and the American people in defeating President Carter's hospital cost containment proposal in 1979. Since then, hospital costs have risen 150 percent, health care costs generally have risen 166 percent, and 13 percent of the Gross National Product now goes to health care.

In short, what we've had over the last 10 years has been an unleashing of market forces. And what we've learned is, when market forces are unleashed, health care costs go up.

Opponents of health care reform have repackaged the market-based solution as "managed competition." Now I believe that consumers ought to have the choice of enrolling in financially stable, well-run, quality managed care plans like Kaiser-Permanente. But, as the Congressional Budget Office and other reputable economists have concluded, there is simply no reason to believe that competition among managed care plans will, by itself, stop the upward march of health care costs.

Of course, the lessons of history, and the weight of analysis will not stop the Administration from believing. But theirs is a fantasy that we

can no longer afford.

Fantasy #5: We can reform the health care system in this country by letting the States do it.

This is the fantasy to which the Bush Administration seems to cling most tightly. They believe that if we would just unleash the creative powers of the laboratories of democracy, there would be no need for the Federal government to act. In fact, the Federal government would save lots of money because the States would be so much more efficient in operating their own health care programs. All the Federal government needs to do is waive its restrictions and mandates, make sure the State's program does not increase Federal spending, and then sit back and watch as the health care system is reformed.

Fantasy.

The paradigm for the "let the States do it" fantasy is the Oregon Medicaid rationing experiment. Although the Administration has been vehement in its opposition to government rationing of health care, it is reportedly on the verge of approving Oregon's proposal to ration health care benefits to poor women and children now eligible for Medicaid. If this proposal is approved and Oregon begins to limit covered services to its poor, we in California will find more and more medical migrants from our neighbor to the North coming to the doors of our State University and State College hospitals for medically necessary, appropriate procedures for which payment is denied in Oregon.

Believe me, I'm as frustrated as any of you at the inability of the Federal government to break through the gridlock on this issue. And it is certainly encouraging that you at the State level would want to move forward on your own.

But let's face facts. There are two major problems the States simply cannot solve individually: cost containment and financing for the uninsured. And without solutions to these problems, health care reform can't be achieved.

Think about cost containment for a minute. If California were to impose effective controls on hospital and physician costs, many providers would move to States without such controls in order to maintain or increase their incomes. One place they might move is Oregon, where the legislature has guaranteed them payment of their full costs and immunity from malpractice liability for denying treatment for any services that the legislature decides not to fund.

The resulting political pressure on you in the California legislature would make an effective cost control effort unsustainable. And from a national perspective, we would not make much a dent in the health care cost problem.

The financing problem is even more daunting. As weak as California's economy is right now, it is much healthier than those of many other States. "Only" -- and I use the word advisedly -- 20 percent of California's population is uninsured, yet I think most of you would tell me that California can't afford to guarantee access to basic health care

services for all of its citizens. What of the States with weaker economies and more uninsured?

If a State wants to pay for its uninsured out of general revenues, it has to face up to the reality that the rate of increase in health care costs is far greater than the rate of increase in general revenues. Even a basic benefit package will get more and more expensive each year, and the State will have to divert funds from other programs.

Could the State protect itself by controlling costs? Not in the long run. Slapping on stringent cost controls won't work, because providers will simply leave for unregulated pastures.

Could the State lower the demand on its general revenues by requiring a contribution from its employers? Yes, but only if it is willing to makes its business climate much less attractive than that of neighboring States that have no such requirement.

In short, health care reform in this country is going to require a major role by the Federal government in both cost control and financing. The States simply can't do it alone.

Health Care Reform Options in Congress

Let me review for you briefly the two major options that Congress is currently debating: play or pay, and the single-payor option.

The proposal I've introduced is based on the recommendations of the Pepper Commission, which called for employers to provide health care coverage to their employees and dependents. They could either purchase private policies, administer their own plans, or enroll their workers into a new Medicare-like public program.

For people who are outside the workforce, the bill would provide coverage through a new, federally-financed public program -- a program which would be completely independent of Medicaid and the welfare system. The elderly would continue to receive coverage through Medicare.

Single Payor and Compromise

Under a single payer approach, all Americans would be covered for basic benefits through federal and State governments rather than through their employers or private insurers.

My view has always been that, while employer choice and single payor plans are different, they share the common objectives of universal coverage and cost containment. And this agreement far outweighs any differences in design.

We can't allow the differences between these approaches to block achievement of health reform, because either of them is clearly superior to the status quo.

During the last few weeks I have been exploring with Chairman

Dingell a health reform proposal that the Energy and Commerce Committee could report. We have agreed to work together to develop a plan with universal coverage and strong cost controls.

I can't give you any details on this yet, but I can tell you that under the proposal, all Americans will be entitled to coverage for basic health care benefits, including hospital, physician, diagnostic, and preventive services and prescription drugs. The Federal government would act as a collector of revenues, and individuals would have a choice of coverage through a public plan, private managed care arrangements, and -- at State option -- a State-run program.

Conclusion

Chairman Dingell and I are committed to finding a majority on the Energy and Commerce Committee for comprehensive health care reform this spring. I know that Chairman Rostenkowski intends to report out legislation as well. And I know that the House Leadership wants very much to bring a bill to the floor and send it to the President this year.

It's unclear whether Congress will complete this agenda this year. While I haven't given up hope, my optimism is limited. But the very nature of the problem and its growing impact on millions of individuals, on health care providers, and on the system itself, demands that we find a solution -- sooner rather than later. I look forward to assisting in your efforts, and your continued support for ours.

Remarks of
HENRY A. WAXMAN, CHAIRMAN
Subcommittee on Health and the Environment
to the
Coalition of High Volume Medical Assistance Hospitals
May 11, 1992

Good afternoon. I appreciate the opportunity to speak to hospitals that have decided not to run from this country's social problems, but to help solve them.

For the past 5 years, the public hospitals and the children's hospitals have been leading the fight to insure that Medicaid protects those institutions that serve large numbers of program beneficiaries and uninsured Americans. I'm sure they are thankful that private community and teaching hospitals are now organizing to join in this effort. I hope that you will work closely with their national organizations, the National Association of Public Hospitals (NAPH) and the National Association of Children's Hospitals and Related Institutions (NACHRI), in taking a unified message to the Congress.

The Administration and Disproportionate Share Hospitals

I understand that you heard this morning from the Administration, and I assume they tried to persuade you about the advantages of Medicaid managed care. I hope that, as you think about the Administration's proposals on this and other Medicaid issues, you will consider their track record with respect to your institutions.

As you know, the requirement that Medicaid payments for inpatient hospital care compensate for the burden placed on facilities serving disproportionate numbers of low-income patients was first enacted in 1981.

For the next five years, the Administration looked the other way while most of the States completely ignored this requirement. When a handful of States, like Georgia, actually tried to comply with the statute, they were told that the Administration's upper payment regulations prohibited anything other than token disproportionate share payment adjustments.

In 1987, the Congress put some teeth into the disproportionate share payment provision. It defined a minimum class of institutions that were entitled to the payments and it eliminated the upper payment limit.

The Administration fought the change.

In 1988, the Congress acted to assure that disproportionate share hospitals were fully compensated for the costs of taking care of low birthweight infants who required long stays.

The Administration fought the change.

In 1990, the Congress acted to allow States to use a payment formula that results in different levels of payments to different classes of hospitals.

The Administration fought the change.

In 1991, the Administration demanded a permanent, national cap on the amount of disproportionate share payments. Unfortunately, the Congress agreed to this, and now these payments will be limited to 12 percent of overall Medicaid spending, regardless of how many patients need the services of disproportionate share hospitals.

I will not be surprised if the Administration comes forward with a proposal to ratchet the 12 percent cap down to 10 or 5 percent as a way of limiting the use of intergovernmental

transfers by the States to pay for their Medicaid programs.

Why is the Administration so hostile to the notion of disproportionate share payments?

First, they want to cut Federal spending on Medicaid. The Federal share of adjustments to disproportionate share hospitals is expected to rise from $3.2 billion last year to $8.9 billion this year. Obviously, clamping down on payments to these institutions will lower Federal spending.

Secondly, the Administration doesn't want Federal Medicaid dollars to pay for services to the uninsured. That's obviously one of the purposes of disproportionate share payments, since these hospitals don't have a large privately insured patient base with which to subsidize their uncompensated care.

The Administration believes that we shouldn't rely on Medicaid to solve the problem of the uninsured, that we need a broader solution. You can read the President's white paper on this subject. You can't read his bill, because he doesn't have one. And while you're reading, you can continue to serve the uninsured.

Ultimately, we come to ideology. The Administration simply does not believe that the Federal government has a financial responsibility to protect the health care providers that serve the poor. In their view, either the market or the States will protect your institutions -- but not the Federal government.

Managed Care: Stealth Repeal of Disproportionate Share Protections

I think we are now entering a new phase of the Administration's struggle against Federal spending on disproportionate share hospitals. To their credit, they are consistent. And, they are getting more sophisticated in their tactics.

Instead of proposing to repeal the disproportionate share protections directly, they are going at it indirectly, camoflaging their policy in everyone's favorite magic bullet -- managed care.

The Administration calls managed care "health care reform." But make no mistake: it is a stealth repeal of the protections that Congress enacted in 1981, 1987, 1989, and 1990.

As you know, under current law, Medicaid beneficiaries are entitled to receive services from the hospital of their choice. If a beneficiary elects to go to a disproportionate share hospital, that hospital is entitled to a payment adjustment.

This freedom to choose a provider is subject to waiver. In some States, like my own State of California, it has been waived. But even in those States, the disproportionate share hospitals with which the State contracts are still entitled to payment adjustments.

What the Administration wants to do is to repeal freedom of choice in order to enable the States to require Medicaid beneficiaries to enroll in managed care plans that serve only Medicaid patients. Under their model, as in Dayton and in Philadelphia, States would hand out geographic franchises to a selected plan, like the Dayton Area Health Plan or HealthPASS. All beneficiaries living in those areas would have to use providers that subcontract with those plans.

There would be no rules for how the plans paid their subcontractors, or how much risk they shifted to them, or who would bear the loss if the plan became insolvent.

If a plan didn't want to subcontract with a disproportionate share hospital, it wouldn't have to.

If it wanted to subcontract but didn't want to make a disproportionate share payment to the hospital, it could do so.

If it wanted to shift much of its risk to its subcontracting hospitals, it could do so.

If it went into bankruptcy, the hospitals and other subcontractors would have to absorb the loss. In the case of the Maxicare bankruptcy in 1988, subcontracting Philadelphia hospitals -- some of whom are represented in this room today -- were owed about $30 million.

What negotiating leverage would a hospital have? Well, without clear statutory protections, very little. The State and the plan -- not the beneficiary -- would control where the beneficiary could receive care. Ironically, the more Medicaid patients a hospital serves, the more dependent it is on Medicaid revenues, and the less leverage it has.

You're probably thinking to yourselves, the way to beat this is to become the plan for your area. Well, for some of you that might work. In other cases, however, someone who was more interested in cash flow and less interested in quality care might come in and underbid you. And even if you won the main contract, there is no guarantee that the capitation rates the State would pay will be adequate, since the Administration proposal does not specify any minimum.

The Administration proposal does specify a ceiling on payments, however. They obviously don't want the States to be too generous. The ceiling would be set at 100 percent of the fee-for-service rate. You know better than I how inadequate this is. According to the Prospective Payment Assessment Commission, in 1989, Medicaid payments for hospital services averaged 78 percent of costs; in some States, like Oregon and Illinois, Medicaid paid less than 60 percent of costs.

Whether it's managed or not, 100 percent of an inadequate fee-for-service base is just that -- 100 percent inadequate.

In short, I would urge you to look very, very carefully at the Administration's managed care proposals, and what they would mean to you over the long run. If these proposals go forward, you should make sure that the Congress protects your institutions against chronic underpayment, excessive risk, nonpayment, and exclusion from the Medicaid market altogether.

Coming Issues

Managed care is not just the Administration's way to repeal the disproportionate share protections without formally doing so. It is also an effort to lay the groundwork for the adoption of a cap on the annual rate of increase in Federal Medicaid spending.

As you know, Federal outlays for Medicaid have been growing rapidly, in part because some of the States are paying at much more reasonable levels for hospital and physician services. This year the Federal government will spend about $68 billion on Medicaid; next year, that is expected to increase to $80 billion.

The Administration's response to this high growth is to look for ways to shift it to the States. That's why Mr. Darman has called repeatedly for a "growth cap" on entitlements. What that really means is a cap on Federal spending for Medicaid and Medicare. I don't have to tell you which of those two programs is more vulnerable politically.

Since the Senate failed to adopt an entitlement cap last month, I don't expect the issue to resurface this year. But I can virtually guarantee you that, if it is reelected, the Administration will be back to Congress the first thing next year pushing very hard for a cap.

I hope that you will join with me in opposing it.